STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner

v **File No. 84861-001**

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 3rd day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On September 4, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on September 11, 2007.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. BCBSM submitted its response on September 19, 2007.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The contract is BCBSM's *Group Conversion Comprehensive Health Care Benefit Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner underwent physical therapy treatment from January 19, 2007 through May 3, 2007. These services were provided by XXXXX. The total amount charged for the physical therapy was $4,373.00. BCBSM covered services from January 19, 2007 through March 19, 2007 in the amount of $1,351.62. BCBSM did not cover the therapy provided from March 23, 2007 through May 3, 2007 because it believes the Petitioner's physical therapy benefits had been exhausted. The amount charged for the denied services was $3,021.38.

The Petitioner appealed the denial of coverage. BCBSM held a managerial-level conference on July 17, 2007, and issued a final adverse determination dated July 30, 2007. The Petitioner has exhausted BCBSM's internal grievance procedures.

III
ISSUE

Is BCBSM required to provide coverage for the physical therapy the Petitioner received from March 23, 2007 through May 3, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner requested a comprehensive benefits booklet from BCBSM in January 2007 that clearly specified the physical therapy benefit for which she was eligible. She was sent a Benefits Summary of Health Care Plans chart, which states the physical therapy benefit as "60 consecutive, renewable days." To be absolutely sure what that term meant she asked BCBSM four more times for clarification so she would not exceed her benefits. Unfortunately, it was not until she had exceeded the benefit that she was informed that it meant 60 calendar days, including Saturdays, Sundays, and all holidays, beginning the first day of services.

The Petitioner believes that the key issue was that BCBSM failed to properly inform her of her physical therapy benefit. She maintains that on two occasions she was informed by BCBSM that the physical therapy benefit meant 60 sessions which could be renewed for a total of 120 sessions.

The Petitioner argues that she fell on the ice on February 9, 2007, which exacerbated her hip condition. Therefore she would be entitled to a second sixty day period, which would cover the care provided from March 23 to May 3, 2007.

Petitioner says that because she was not informed of her proper benefits and because she exacerbated her condition she believes that BCBSM is required to pay for all of her physical therapy.

Respondent's Argument

The certificate provides in *Section 3: Coverage for Physician and Other Professional Provider Services:*

> We pay for physical therapy, speech and language pathology services, and occupational therapy to treat disease or injury. These benefits are payable for 60 consecutive days of treatment per condition. . . . The 60-day period begins with the first day of treatment. The 60-day benefit per condition is renewed:
>
> - Each calendar year
> - Immediately after surgery for the condition that was treated or
> - Following a distinct aggravation of the condition that was treated

In the Petitioner's case, coverage for her treatment began January 19, 2007 and ended 60 days later. She continued her physical therapy until May 3, 2007, however. It is BCBSM's position that the Petitioner's condition did not change. She had indicated that her condition did change, but did not provide any supporting documentation from XXXXX as to when and how her condition was different. Therefore, BCBSM believes that the physical therapy provided to the Petitioner was appropriately denied for the period March 23, 2007 until May 3, 2007.

Commissioner's Review

The Petitioner believes that BCBSM misinformed her about her physical therapy benefit in phone conversations and when it failed to provide her a copy of her certificate prior to the start of her therapy. Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of the factual dispute described by the Petitioner cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

Covered benefits are listed in the certificate which states that physical therapy benefits are available for sixty consecutive days of treatment per condition. These benefits are renewable (1) each calendar year, (2) after surgery for the condition that was treated, or (3) following a distinct aggravation of the condition that was treated. The Petitioner argued that her hip condition was aggravated in a fall on the ice on February 9, 2007. The therapy clinic notes for that date indicate the Petitioner said, "I was doing better until I fell." The therapist's notes indicate "Pt. fell on ice this morning." There is no other medical information in the submitted materials concerning this fall. There is no evidence in the medical records of an additional diagnosis or treatment plan concerning this fall. There is also no information indicating how the fall may have aggravated the original problem for which the physical therapy was prescribed. In the absence of such information, it is not reasonable to conclude that Petitioner received a "distinct aggravation of the condition that was treated."

The Commissioner finds that BCBSM correctly applied the provisions of Petitioner's certificate of coverage. BCBSM paid for the physical therapy provided to the Petitioner in the sixty day period after the first date of service. Therapy provided from March 23, 2007 to May 3, 2007 is not a covered benefit and BCBSM is not required to cover it.

V
ORDER

BCBSM's July 30, 2007, final adverse determination is upheld. BCBSM is not required to cover the Petitioner's physical therapy provided from March 23, 2007 until May 3, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.